THE RECOVERY KERNEL

How to Navigate the Recovery Kernel

For People Recovering from Methedrone

4-methoxymethcathinone (bk-PMMA, PMMC, methoxyphedrone): a synthetic cathinone sold as a "research chemical" or "bath salt." A step-by-step route: what to read, in what order, and what to expect. It includes the interaction and polypharmacy questions the Kernel treats as central.

> **HARM REDUCTION RESOURCE — NOT MEDICAL ADVICE. METHEDRONE HAS BEEN LINKED TO FATAL OVERDOSE AT AMOUNTS CLOSE TO THOSE REPORTED RECREATIONALLY. THE MARGIN OF SAFETY IS UNUSUALLY NARROW.** Go to an emergency department or call 911 for a dangerously high temperature, uncontrollable muscle twitching or rigidity, escalating confusion or agitation, a racing or irregular heartbeat, a seizure, or loss of consciousness. These can mean serotonin syndrome or delirium. Tell responders that a synthetic cathinone (methedrone, bk-PMMA, 4-MeOMC) was used and name everything else taken, including prescriptions.
>
> **Serotonin syndrome:** agitation or confusion, fever, rapid heartbeat, high blood pressure, dilated pupils, heavy sweating, diarrhea, tremor or twitching, rigid muscles. It can start within hours and progress fast, and it applies during use and for at least several days after the last use. Fentanyl contamination has been documented across the cathinone supply, so carry naloxone. Never use alone.
>
> Crisis: call or text 988 · SAMHSA: 1-800-662-4357 · Crisis Text Line: text HOME to 741741

1. Before you start

This is a route through the Recovery Kernel for people whose use of methedrone has become a problem, and for the friends and clinicians around them. The Kernel makes two points that shape everything here. First, methedrone is not like the cathinones people usually mention. Mephedrone and methylone lean toward dopamine and norepinephrine. Methedrone, per the Kernel, is a strong inhibitor of the serotonin and norepinephrine transporters and only a weak one of the dopamine transporter, and releases all three, so it behaves more like MDMA or the para-methoxy amphetamines (PMA, PMMA), which have a long record of deaths out of proportion to their use. It also reportedly has weak, reversible MAO-inhibiting activity and a long half-life of roughly a day. Second, the most dangerous moment in stopping is often not the withdrawal but an uncoordinated interaction with something else in your system, prescribed or not. Six rules follow.

- **Tell your prescriber everything.** A full list of what you take, prescribed, over-the-counter, and recreational, with the timing of your last use, is the single most protective step.
- **No unilateral changes.** Do not stop or adjust an antidepressant on your own, and do not make two changes at once (methedrone and an antidepressant) without medical coordination.

- **There is no safe schedule.** The Kernel gives no dosing threshold, redosing interval, or taper for methedrone and says none exists that is credible. This guide does not either.
- **The product may not be methedrone.** It may be another cathinone or something else entirely, at an unknown strength.
- **Serotonin precursors need a physician.** 5-HTP and tryptophan carry a real serotonin syndrome risk, including from methedrone's own residual effect in the first days.
- **Waves are expected.** With a compound this strong on serotonin and this slow to clear, mood dips can come for months. They are not a verdict on recovery.

How chapters are cited. "Main Book" is the Recovery Kernel Main Book (Second Edition, Centurian). "Compendium" is the Complete Protocol Compendium. "Supp. Ch. N" is chapter N of the Supplemental Book. The core chapters are Chapter 16 (How to Recover from Methedrone) and Chapter 34 (Discontinuance Protocol: Methedrone and Polypharmacy). Section numbers (§) refer to sections inside those chapters. The Kernel points to the core stimulant guide (Chapter 11) for the dopamine side.

> **A note on protocol numbers.** Supplemental Chapters 16 and 34 cite Compendium protocols by number, and some numbers do not match the Compendium as printed. They call Protocol 01 "Shelter & Stabilization" (printed: Emergency Triage), Protocol 09 "Sleep Architecture" (printed: The Gut-Brain Axis; sleep is Protocol 17), Protocol 05 "Environmental Redesign" (printed: Digital Detox), and Protocol 28 "Natural Addiction Porting" (printed: The Recast, Centurian Paper C-28). They also send genomic phenotyping to "Compendium Section 15". This guide cites each protocol by its printed title. If a number and a title disagree, follow the title.
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> For methedrone, the same fast-fade redosing pattern as other cathinones applies, and it compounds this drug’s already narrow serotonergic margin.
>
> Redosing is not the only version of this. Watching peers in a treatment setting negotiate a relapse, getting confident advice from someone untrained in your specific situation, or noticing a prescriber treat a prescribed substance more casually than an illicit one can all trigger the same pattern: a felt doubt read as “the plan must be wrong,” answered by abandoning it. See **The Commandeering Map**, a companion to this series, for the fuller pattern, including how it can differ by genetic profile and what helps when practice-based resistance alone is not enough.

2. The route at a glance

Steps 0 and 1 come first and cannot be skipped. Steps 2 to 4 can run at the same time. Steps 5 to 9 overlap and are the work of the first year. Step 10 is everything after. "P" means Compendium Protocol; "C" means Centurian Paper.

Step	When	What you do	Turn to
0	Day 0	Triage: serotonin syndrome and delirium signs, what else was taken, what the product might be.	Supp. Ch. 16 opening, §1 Supp. Ch. 34 §0 Compendium P01

Step	When	What you do	Turn to
1	Days 0–14	The full-picture medical conversation. Ride out the comedown. Sort your use level.	Supp. Ch. 34 §§1, 2, 6, 7, 8 Supp. Ch. 16 §3
2	Weeks 1–4	Read the Main Book in order.	Main Book: Who This Book Is For, Quick-Start, Part One (Ch. 1–5) Supp. Ch. 2, 3
3	Weeks 1–4	Order 30× whole-genome sequencing. CYP2D6 is the priority.	Supp. Ch. 5 Step 1 Supp. Ch. 16 §2 Compendium P06
4	Weeks 2–6	Resolve your profile. Ask what methedrone was giving you.	Supp. Ch. 5 Steps 2–3, 6 Supp. Ch. 16 §2, §6; Ch. 34 §5
5	Day 1 to Month 6	Build the foundation: methylation, sleep, protein, and receptor support. Precursors only with a physician.	Supp. Ch. 16 §4, §5 Supp. Ch. 34 §9 Compendium P07, P17, P18
6	Weeks 1–12, then ongoing	Craving interrupt, and cues. Redosing decisions are dangerous when alone.	Supp. Ch. 16 §4.4 Compendium P05, P08, P21
7	Weeks 2–24	The function audit and replacement map: connection, emotional openness, energy.	Supp. Ch. 16 §6 Supp. Ch. 11 §6 C-28; Compendium P19
8	Months 1–12	The waves: post-acute withdrawal. Disclosure over secrecy.	Supp. Ch. 16 §3; Ch. 34 §§3–4 Compendium P01
9	From week 1	The medication layer, with a physician who has the whole picture.	Supp. Ch. 16 §8 Supp. Ch. 34 §§6, 8, 9 Compendium P13
10	Months 3+, Year 1 to 10	Identity, connection built rather than borrowed, and stewardship.	Supp. Ch. 42, 43, 44 Compendium C-28, P24, P25 Supp. Ch. 5 Step 6

3. The route, step by step

Step 0 — Triage (Day 0, before everything)

Read the banner and act on it. The Kernel says the serotonin syndrome triad is a change in mental state (agitation, confusion, restlessness), autonomic instability (fever, fast heart rate, high blood pressure, sweating, diarrhea), and neuromuscular signs (tremor, rigid muscles, twitching, overactive reflexes, poor coordination), and that any combination after methedrone, especially with another serotonergic drug, is an emergency. Its list of things that make it worse: SSRIs, SNRIs, MAOIs (prescribed or otherwise), tramadol, dextromethorphan, triptans, St. John's wort, and other serotonergic drugs or supplements, including ones you recently stopped. Combining methedrone with a prescribed MAOI (phenelzine, tranylcypromine, selegiline) is called severe and potentially life-threatening, and is not a situation for a guide or a taper: contact the prescriber immediately, or go to emergency care if any sign is present.

Also ask what you actually had. The Kernel says the compound sold as methedrone may be another cathinone, a mixture, or something outside the family, with no reliable labeling. Reagent kits can show a cathinone is present but cannot confirm methedrone or rule out adulterants, so tell responders and clinicians that you are unsure what it was.

Turn to: Supp. Ch. 16 opening emergency box and §1 (what methedrone did; the para-methoxy problem; the unknown-compound problem). Supp. Ch. 34 §0 (immediate safety). Main Book, Quick-Start Boot Sequence, Step 1. Compendium Protocol 01, Emergency Triage, for an acute crisis state.

Step 1 — The full-picture medical conversation (Days 0–14)

The Kernel says withdrawal from methedrone is not typically the most dangerous phase, and that the danger is the acute period and the interactions. Its plan is disclosure. Bring to a physician or addiction medicine specialist: a complete list of everything taken, prescribed, over-the-counter, and recreational, with the approximate timing of the last use of each; any serotonin syndrome symptoms you noticed during use, even mild or brief ones; your CYP2D6 result if you have one; and a plain statement of your goal (stopping entirely, cutting down, or managing a medication interaction). If you take an antidepressant, tell the prescriber about the methedrone and how recently. Stopping methedrone is one change, and stopping or adjusting an antidepressant is another with its own discontinuation syndrome. Doing both at once without coordination is how people end up with an unmanaged interaction or an unmanaged discontinuation on top of the crash.

The Kernel's use levels set how much medical help you need. Level 1 (one or two isolated uses) and Level 2 (occasional, social) need a check-in if anything concerning happened, and otherwise the biological reconstruction below. Level 3 (regular or escalating) means physician involvement before stopping, especially to review medications. Level 4 (dependent, often with other stimulants, GHB, or serotonergic medication) means medical supervision, and no coordinating several stops at once without a physician. If other substances are involved, read the matching guides in this series alongside this one: methamphetamine, GHB, and benzodiazepines each carry their own withdrawal risks, and alcohol or benzodiazepines can mask early warning signs of serotonin toxicity.

The timeline the Kernel gives. Comedown, 12 to 48 hours after the last use: fatigue, low mood, irritability, and fog, slower to arrive and to lift than with fast-clearing cathinones. Days 2 to 10: depressed mood, anhedonia, poor sleep, appetite change, and anxiety, often flatter and more depressive than a pure dopamine crash. Weeks 2 to 6: sleep and appetite normalizing, mood fragile, craving cue-driven. Months 1 to 12: waves of low mood, fog, and craving. Low mood, fatigue, and poor sleep without the emergency signs are expected and warrant same-day contact with a physician, not the emergency department.

Turn to: Supp. Ch. 34 §§1–2 (why polypharmacy is central; the withdrawal timeline), §6 (the combinations that matter most), §7 (use-pattern classification), §8 (the medical detox protocol: what to bring). Supp. Ch. 16 §3 (the detox protocol).

Step 2 — Read the Main Book (Weeks 1–4)

Read it in order once you are stable. If you are overwhelmed, the Quick-Start Boot Sequence is designed to be read on its own. Read "Who This Book Is — and Is Not — For" first: it names situations where the supplement protocols need medical modification, including active psychosis, pregnancy, and severe liver disease.

Read in this order: Who This Book Is For → Quick-Start Boot Sequence → Part One: Ch. 1 (Why Willpower Isn't Enough), Ch. 2 (MTHFR), Ch. 3 (COMT), Ch. 4 (CYP450, the chapter on CYP2D6), Ch. 5 (When Systems Collide) → Ch. 7 (Harm Reduction), only if you are still using → Part Two, the case files (Chapter 6). Ch. 8 (Oxytocin Protocol) is experimental and specialist-only. Ch. 9 (Epigenetic Playground) belongs to Steps 7 and 10. Appendix A (which includes the interaction matrix) and Appendix B are reference.

Then add: Supp. Ch. 2 (Clarity · Restoration · Manning). The Kernel has no methedrone case study. The nearest are Case 06 (MDMA, a serotonin and connection profile) and Case 05 (meth). Supp. Ch. 11 (the core stimulant guide) for the dopamine side, and Supp. Ch. 14 (MDMA) for the serotonin side. Supp. Ch. 3 (The Addict Virgin Problem) recalibrates timelines. Supp. Ch. 1 (Why They Left You There) is optional reading for the shame.

Step 3 — Get your DNA (Weeks 1–4)

The Kernel's recommended route is 30× whole-genome sequencing, which returns a VCF file, a one-time asset you keep. A consumer SNP array is an acceptable start. A clinical pharmacogenomic panel adds clinical-grade CYP calls, and CYP2D6 is worth prioritizing. Homocysteine, B12, and RBC folate are functional markers you can recheck quarterly.

The panel, per the Kernel: **CYP2D6** (poor metabolizers may clear the compound and its metabolites more slowly, prolonging exposure and interaction risk, which matters given the PMA/PMMA family's toxicity record), **SLC6A4** (shapes the intensity of the serotonergic effects and the vulnerability to overload, including with antidepressants), **MAOA** (baseline monoamine breakdown, relevant to the reported MAO-inhibiting effect), **COMT**, **DRD2/ANKK1**, and **MTHFR**. Until results arrive: did methedrone feel warm, connective, and emotionally opening more than sharply energizing (a strong serotonin component); were effects slow to arrive and slow to leave; do you take or recently take an SSRI or other serotonergic drug (the most important thing to disclose); do you struggle with depression, blunting, or fatigue even when clean (methylation)?

> **Confirm what you are ordering.** Supp. Ch. 5 specifies 30× whole-genome sequencing with VCF output. "WGBS" more commonly names whole-genome bisulfite sequencing, a DNA-methylation assay that is not built to call variants such as MTHFR C677T. Ask the lab for a standard variant file (VCF).

Turn to: Supp. Ch. 5, Step 1. Supp. Ch. 16 §2 (the DNA panel for methedrone recovery; reading your profile before you have results). Supp. Ch. 34 §5 (genetic cross-reference). Compendium Protocol 06, Phenotype Assessment. Main Book Ch. 2 and Ch. 3 self-assessments.

Step 4 — Resolve your profile (Weeks 2–6)

Write your profile down and carry key results on a card. If you know or suspect you are a CYP2D6 poor metabolizer (from testing, or from unusually strong or prolonged reactions to other drugs the enzyme handles, such as certain antidepressants, opioids, or beta-blockers), tell every physician.

If your result is...	What changes	Source
CYP2D6 poor or intermediate	Slower clearance of methedrone and its metabolites, so exposure and interaction risk may last longer after the last use than typical timelines suggest. Tell any physician managing your medications.	Supp. Ch. 16 §2; Ch. 34 §5
SLC6A4 short/short	A stronger serotonin effect and more sensitivity to serotonin syndrome when combinations occur, plus a more severe serotonergic withdrawal. Serotonin support needs physician input.	Supp. Ch. 16 §2; Ch. 34 §5
MAOA low-activity	Less baseline breakdown of monoamines, so more load already, and more risk from the compound's own reported MAO-inhibiting effect and from co-used substances.	Supp. Ch. 16 §2; Ch. 34 §5

If your result is...	What changes	Source
COMT Val/Val or Met/Met	Val/Val (Warrior): the intensity was sought, so the dopaminergic component of recovery needs a real intensity architecture. Met/Met: more anxiety and a heavier stress-chemical load, and connection and calm are the targets.	Supp. Ch. 16 §2, §6; Ch. 34 §5
DRD2 A1	Fewer D2 receptors, the reward-deficiency vulnerability common to stimulants. Build several reward sources.	Supp. Ch. 16 §2
MTHFR variants	Reduced capacity to rebuild serotonin, dopamine, and norepinephrine, and often the depression, blunting, or fatigue that persists when clean. 5-MTHF first.	Supp. Ch. 16 §2, §4.1; Main Book Ch. 2

Turn to: Supp. Ch. 5, Steps 2, 3, and 6 (gene systems, combined profiles, profile template). Supp. Ch. 16 §2 and §6. Main Book Ch. 5 and Appendix A.

Step 5 — Build the foundation (Day 1 to Month 6)

The Kernel says reconstruction here has to cover both serotonin and dopamine, and that everything in this step should be discussed with a physician first, because of the compound's serotonergic mechanism and reported mild MAOI activity. Methylation: 5-MTHF, the active folate the brain can use regardless of MTHFR status. Sleep, which it calls a medical priority: consistent sleep and wake times even when sleep is poor, and magnesium glycinate and L-theanine as low-interaction, non-serotonergic supports, avoiding stacked serotonergic sleep aids such as high-dose 5-HTP. The Kernel's post-acute foundation also lists omega-3 (EPA and DHA) and consistent protein and regular meals for neurotransmitter synthesis and blood sugar. Precursors: serotonin precursors (5-HTP, tryptophan) only with physician clearance and confirmation that enough time has passed; dopamine precursors (tyrosine) carry lower interaction risk, but wait until acute withdrawal has stabilized and still discuss them. Receptor rehabilitation follows the core stimulant framework, aimed at both D2 and serotonin receptors, which is part of why the waves run longer. No doses are given here. Run every addition past a pharmacist and an interaction checker (Drugs.com or Medscape).

Turn to: Supp. Ch. 16 §4.1 (methylation), §4.2 (serotonin and dopamine precursor support: the physician-only caution), §4.3 (receptor rehabilitation), §5 (rebuilding sleep). Supp. Ch. 34 §9 (the post-acute recovery protocol). Supp. Ch. 5, Phase One. Main Book Ch. 2, §2.4–2.5. Compendium Protocol 07 (Neuroplasticity), Protocol 17 (The Nightly Restoration), Protocol 18 (Eating for Restoration), and Centurian Paper C-32 (The Insomnia Architecture).

Step 6 — The craving, the cues, and the redosing decision (Weeks 1–12, then ongoing)

The Kernel says a craving is a neurological event, not a moral failure. Its interrupt: locate it in the body and name where it sits; at least four cycles of 4-7-8 breathing; change your physical environment and move away from the cues; make contact with one person, since isolation is where cravings, and with this compound redosing decisions, become dangerous; do your highest-intensity healthy micro-reward for the next ten minutes; and document the trigger, the intensity, and what happened. The Kernel also says isolation and secrecy, especially around what else you take, are risk factors, so connection and disclosure are part of the protocol, not extras. Cut supplier contacts, since the product is unpredictable, and plan for the party and event contexts where it was used.

Turn to: Supp. Ch. 16 §4.4 (the craving interrupt protocol). Supp. Ch. 34 §9 (connection and disclosure). Compendium Protocol 05 (Digital Detox), Protocol 08 (Social Environment), Protocol 21 (Reading the Collapse). If methedrone was part of chemsex: Supp. Ch. 29.

Step 7 — The function audit and the replacement map (Weeks 2–24)

The Kernel says methedrone's pull often had as much to do with connection, warmth, and emotional openness as with intensity, closer to the MDMA pattern than the meth or cocaine pattern. The function audit: what did it actually give you (emotional openness, felt connection, warmth or safety in social settings, relief from flatness or isolation, and energy or focus)? Each is a real need that did not vanish. The replacement map: for connection and warmth, community that rebuilds genuine emotional safety (group therapy, structured peer support, deliberately vulnerable friendships), not just more socializing; for emotional openness, contemplative and somatic practices (breathwork, structured journaling, therapy such as EMDR or IFS if there is a relevant history) that reach emotional material without a chemical shortcut; and for the energy component, if present, the physical, mastery-oriented, socially staked activity architecture from the core stimulant guide.

> **A caution this guide adds (not in the Kernel).** Hyperventilation-based breathwork can provoke panic or dissociation in people with a psychosis history, seizure history, heart conditions, or persistent perceptual disturbances. If any of those applies, ask your clinician before trying it, and start with slow breathing and grounding.

Turn to: Supp. Ch. 16 §6 (porting the addiction: the function audit; the replacement map). Supp. Ch. 11 §6 (the stimulant natural architecture). Supp. Ch. 14 §6 (the connection architecture). Centurian Paper C-28 (The Recast). Compendium Protocol 19 (The Body in Motion), Protocol 29 (The Peacetime Paradox).

Step 8 — The waves (Months 1–12)

The Kernel puts the central recovery phase after sustained use at 4 to 12 weeks, with intermittent post-acute episodes for up to a year. For occasional or experimental use, acute symptoms usually clear in one to two weeks. It says mood dips that seem to come from nowhere are a documented pattern, not a new condition and not a sign recovery has stalled, because a compound this active on serotonin with this long a clearance time gives the nervous system more to rebuild. Expect vivid or unsettled dreams as serotonin regulation normalizes, and remember withdrawal may be hard to tell apart from rebound from other substances, which is one more reason to keep one medical picture. Use the breathwork practice daily (the Kernel calls it non-negotiable), regular gradual aerobic exercise, steady sleep timing, and connection. Call a physician for low mood, fatigue, and sleep problems that are hard to carry, and call 988 if you feel unsafe.

Turn to: Supp. Ch. 16 §3 (the withdrawal timeline; PAWS). Supp. Ch. 34 §§2–4, 9. Compendium Protocol 01, Emergency Triage.

Step 9 — The medication layer (from week 1)

There is no FDA-approved medication for methedrone or synthetic cathinone use disorder, and no standardized detox protocol for this compound, which the Kernel calls a genuine gap. Off-label options for stimulant or serotonergic-compound recovery (bupropion, buspirone, certain antidepressants) each carry their own interaction issues with a recent methedrone history, which is why the Kernel says a physician, not self-directed supplementation, handles the medication layer. Decisions about whether or when to restart or add an antidepressant, or review one already in use, belong to that conversation, not to a supplement list. Bring your genomic panel and a full account of everything you take or recently took.

Turn to: Supp. Ch. 16 §8 (the medical support layer). Supp. Ch. 34 §6 (polypharmacy: prescribed antidepressants, other stimulants, alcohol and benzodiazepines, MAOIs), §8 (what to bring). Compendium Protocol 13 (The Pharma Trap).

Step 10 — Identity and the long game (Months 3+, Year 1 to Year 10)

The Kernel's closing: the pull toward connection, emotional openness, and relief from a baseline that felt too flat or too isolated is not broken. It found methedrone because methedrone offered a fast chemical version of something real and legitimate to want, and the work is building the real version, at a pace and through channels that do not carry a narrow margin for error. Full Inventory is a structured 180-day plan, and Amends to Self puts the person who lived through it first. Navigation after the first year shifts from repair to stewardship. Section 4 shows how. Standing tools: Supp. Ch. 44 (The Transplant: redirect the devotion and daily structure the pattern required into a practice that grows). Supp. Ch. 6 (Stay Non-Addicted) and Compendium Protocol 02 (Behavioral Addictions, with its "Mask Change" caution on addiction transfer). Compendium Protocol 13 (The Pharma Trap). Supp. Ch. 38. Supp. Ch. 5, Step 6 (a weekly AI check-in profile, a reasoning tool and never a provider).

Turn to: Supp. Ch. 42 (Full Inventory). Supp. Ch. 43 (Amends to Self). Centurian Paper C-28 (The Recast). Compendium Protocol 24 (Returning to Work), Protocol 25 (The Open Door), Protocol 22 (The Family Field), Protocol 16 (The Isolation Spiral). Supp. Ch. 51 (Family & Support Network Guide): give it to the people who love you.

4. How navigation changes at Years 3, 5, and 10

Shading shows how much attention each track needs. Darkest is primary focus, then active, then maintenance. White cells with gray text are standing safeguards: low effort, never dropped. Numbers in brackets refer to the shifts listed below the table. The Kernel's methedrone timeline ends at about 12 months, so later years are projection.

Track	Months 0–24 (foundation)	Year 3 (consolidate)	Year 5 (build out)	Year 10 (steward)
Safety and interactions	Med list told; no serotonin mixing	Meds reviewed; SSRI caution [1]	Prescribers know your history	No mixing; no unknown supply [7]
Biology and genome	CYP2D6 first; SLC6A4, MAOA	Retest labs; step stack to upkeep [2]	Prescriber card: CYP2D6, MAOA	Re-check with new meds and age
Supply and cues	Supplier cut; party cues cut	Cues fainter; plans made ahead	Triggers shift: loneliness, scene [5]	Same plan, rehearsed
Serotonin and sleep repair	Sleep first; methylation base	Systems settling; waves rarer [3]	Mood plan, clinician-led	Stress plan, sleep habits
Connection and openness	Safe people; somatic, group work	Real closeness, built not borrowed [4]	Vulnerability practiced weekly	Circle renewed; depth kept
Intensity architecture	Exercise daily; if Warrior profile	Mastery ladder carries the load	Several intense outlets	Intensity outlets, still weekly
Identity and Manning	Purpose: first seeds only	Transplant; return to work	Manning: peer support [6]	Mentor or run a group

The seven shifts

1. **Year 3, medications are reviewed, with SSRI caution.** If you were started on an antidepressant during recovery, the Kernel's rule stands: serotonergic drugs and methedrone or any similar compound do not mix, and precursor supplements need a physician (Supp. Ch. 16 §4.2; Ch. 34 §6). Review each medication with the standard in Compendium Protocol 13 and keep your prescriber informed.
2. **Year 3, the stack moves from building to upkeep.** The Kernel places the post-acute phase within about a year (Supp. Ch. 16 §3). Retest labs (Supp. Ch. 5 Step 1a) and step down toward maintenance. The Trinity chapter says supplements are taken until stable, then tapered and resumed if the system destabilizes; Main Book Ch. 2 treats MTHFR support as maintenance, not cure. Step down to maintenance, not to zero.
3. **Year 3, the systems have settled and the waves are rarer.** The Kernel says post-acute waves can run up to a year (Supp. Ch. 34 §3). By year 3 mood, sleep, and cognition should be steady, with an occasional dip understood for what it is.

4. **Year 3, real closeness is built, not borrowed.** The Kernel's closing says the aim is the real version of connection and warmth (Supp. Ch. 16, Final Word). By year 3 that should be a stable circle and a practiced capacity for vulnerability, not a project.
5. **Year 5, triggers shift to loneliness and the scene.** The Kernel names isolation and secrecy as risk factors (Supp. Ch. 34 §9). As the original cues fade, what remains is loneliness, a return to old social contexts, and any situation where an unknown "research chemical" is on offer. This shift is extrapolation.
6. **Year 5, Manning.** This is the Trinity's third stage (Supp. Ch. 2). This is extrapolation: peer support that treats the disclosure conversation as the protective act the Kernel says it is.
7. **Year 10, no mixing and no unknown supply.** The Kernel says the margin is narrow, the product is unpredictable, and serotonergic combinations are synergistic, not additive (Supp. Ch. 16 §1; Ch. 34 §1). That does not change with time, so keep the rule and keep your CYP2D6 result on your card.

What is sourced and what is extrapolated. *Shifts 3, 4, and 7 rest directly on Kernel text. Shifts 1 and 2 apply Kernel rules at a timing chosen for this guide. Shifts 5 and 6 are extrapolations. The Kernel's methedrone timeline ends at about 12 months.*

5. What outcome to expect

The short version

The Kernel has no methedrone case study and gives no 12-month percentages, so this section is qualitative and does not make up numbers. If you do the route above, with the interaction and medication conversation first, the foundation built, the cues and redosing decisions handled, and connection built the real way, this is what the Kernel supports:

- **You get through the acute period safely** because your prescriber has the full picture, no single change is made in isolation, and any serotonin syndrome sign gets emergency care.
- **For occasional or experimental use,** acute symptoms usually clear in one to two weeks.
- **For sustained use,** the central recovery phase, when mood, sleep, and cognition still feel "off" between good stretches, typically runs 4 to 12 weeks, with post-acute episodes for up to a year.
- **By years 3 to 5 the work is maintenance and building. By year 10 you are a steward,** carrying a small set of standing safeguards.

The Kernel does not promise zero risk. It says the acute risk of this compound is the serious one, that the waves are expected, and that the polypharmacy conversation is the most protective single thing you can do.

Milestones, in order

Milestone	When	Expected outcome	Source	Basis
Safe start	Days 0–14	Emergency signs known. Full medication and substance list given to a physician. No unilateral changes. Level 3–4 use supervised.	Supp. Ch. 34 §§0, 6–8	Clinical fact
Comedown	Hours 12–48	Fatigue, low mood, irritability, and fog, slower to arrive and lift than with faster cathinones.	Supp. Ch. 16 §3; Ch. 34 §2	Clinical timeline
Acute withdrawal	Days 2–10	Depressed mood, anhedonia, poor sleep, appetite change, anxiety, often flatter than a dopamine crash.	Supp. Ch. 16 §3; Ch. 34 §2	Clinical timeline
Stabilization	Weeks 2–6	Sleep and appetite normalizing. Mood fragile. Craving cue-driven.	Supp. Ch. 16 §3	Kernel projection
Central recovery	Weeks 4–12 (sustained use)	Mood, sleep, and cognition "off" between good stretches. Occasional or experimental use: acute symptoms clear in 1–2 weeks.	Supp. Ch. 34 §3	Kernel projection
Post-acute waves	Months 1–12	Intermittent low mood, fog, and craving as serotonin and dopamine systems keep rebuilding. Expected, not a verdict.	Supp. Ch. 16 §3; Ch. 34 §3	Kernel projection
Deep-root reversal	2–5+ years (heavy long-term use)	Prefrontal recovery and epigenetic reversal continue. Some changes may be partial.	Supp. Ch. 36	Kernel projection
Steward phase	Years 3–10	Repair tracks at maintenance. Real connection built. Peer support. Standing safeguards.	Section 4 of this guide	Extrapolated

The Kernel's 12-month numbers: none for methedrone

The Kernel has no methedrone case study and gives no methedrone-specific projection, so there is no 12-month table, and this guide will not make one up. The nearest profiles in Supplemental Chapter 2 are Case 06 (MDMA, a serotonin and connection profile) and Case 05 (methamphetamine), and neither is a prediction for methedrone. What the Kernel does offer is the withdrawal timeline above.

What changes the outcome

- **Mixing with serotonergic drugs,** especially an MAOI, or an SSRI, SNRI, tramadol, dextromethorphan, a triptan, or St. John's wort.
- **Changing two things at once,** such as stopping methedrone and an antidepressant without coordination.
- **Hiding the whole picture** from your prescriber. The Kernel says a partial picture changes the plan.
- **Starting 5-HTP or tryptophan without a physician,** especially in the first days.
- **Using alone,** or taking more because the effect is slow to arrive.

- **Trusting the label.** The product may be a different cathinone or something else.
- **Missing a wider pattern:** methedrone inside chemsex, or alongside meth, GHB, alcohol, or benzodiazepines.
- **Isolation and secrecy,** which the Kernel names as risk factors.
- **A lapse.** The Kernel treats it as information, not judgment (Protocol 21). It is also a medical-risk event: do not use alone, tell your prescriber, and go to emergency care for any serotonin syndrome sign.

How to read the evidence behind the outcomes

The Main Book marks claims with an Evidence Tier: Established, Probable, Emerging, Author/System Experience, and Controversial or Mixed. This guide's reading: serotonin syndrome with serotonergic drugs and MAOIs, and the narrow margin of the para-methoxy amphetamine family, are well established. Methedrone-specific data, as I understand it, are thinner: mostly laboratory transporter studies and a small number of toxicology reports, so treat its potency, its reported MAO-inhibiting effect, the half-life of about a day, and the claim that fatal and survived blood levels overlap as approximate. The supplement foundation, the natural-access comparisons, and the years 3 to 10 trajectory sit lower on that scale, so bring them to your clinician as questions, not as facts.

Take these to your clinician

- A complete list of everything you take or have taken: prescribed, over-the-counter, supplements, and recreational, with the approximate time of last use for each, and what you believe the product was.
- Any serotonin syndrome symptoms you noticed during use, even mild or brief: sweating, tremor, twitching, agitation, fever, diarrhea.
- Every antidepressant or other serotonergic drug you take or recently stopped, and a direct question about how to handle it safely before any change.
- Your CYP2D6, SLC6A4, MAOA, COMT, and MTHFR results, and any history of unusually strong reactions to medications.
- A statement of your goal (stopping entirely, reducing, or managing a medication interaction), and whether other substances (meth, GHB, alcohol, benzodiazepines) are part of the pattern.